

Rights & Responsibilities

- Everything I tell WIC must be the truth to the best of my knowledge and may be verified.
- If I am enrolling a child or infant, I must be their legal guardian, custodial parent, or foster parent.
- All information I give WIC is private. WIC staff will not give out this information without my signed release.
- I may only get checks from one WIC program at a time.
- I may not receive CSFP (Commodity Supplemental Food Program) while receiving WIC for the same person.
- The foods given by WIC are only for the WIC client.
- If I do not follow the WIC program rules, I may receive sanction points. If I accumulate too many sanction points I can be taken off WIC.
- Standards for eligibility for WIC are the same for everyone, regardless of race, color, national origin, age, disability or sex.
- If I feel I have been discriminated against I may file a complaint.
- If I disagree with a decision regarding my eligibility, I may request a fair hearing. I may do so by mail, verbally, or in writing to the WIC program. My request must be made within 60 calendar days of when the written denial or termination of benefits was mailed or given to me. A detailed copy of the Fair Hearing Procedures is available on request from the Local Program Director.
- If I am unable to keep my appointment, I should call the local agency number on my ID folder.
- I will report address and/or phone changes at my next scheduled appointment.
- Presumptive eligible pregnant women found to have no nutritional risk within the first 60 days of certification will no longer be eligible for the Program and will receive no additional benefits.
- I am encouraged to participate in the health assessment, referrals & nutrition education available to me through the program.
- If I do not follow the rules for using my WIC checks, or I sell or give away my WIC checks or foods I may be asked to repay the WIC Program the value of the WIC foods received.
- My signature on this form allows staff of the Food Stamp and Food Stamp Nutrition Education Program; Medicaid; Perinatal, Child and Adolescent Health Unit; Newborn Screening; CSFP; and Immunization programs to see the information for purposes of outreach, referral, and eligibility. They cannot share the information with a third party.
- That intentionally making a false or misleading statement or intentionally misrepresenting, concealing, or withholding facts may result in paying the state agency, in cash the value of the food benefits improperly issued to me and may subject me to civil or criminal prosecution under State and Federal law.

RELATIONSHIP TO APPLICANT (Check One)[illegible]

Client Name: _____ ID: _____ Family ID: _____

SECOND RESPONSIBLE PARTY – For Infants & Children

_____ is also the parent and/or guardian of _____ and has the same responsibilities as myself at the WIC clinic and store.

☐ Declined

DUAL PARTICIPATION

By initialing below I agree that the person who is being certified for WIC today is not currently receiving and will not receive for the same time period:

- WIC benefits from another WIC clinic **OR**
- benefits from Commodity Supplemental Food Program (CSFP).

My initials indicate that I understand that this is considered fraud.

Initials: _____ Date: _____

Initials: _____ Date: _____

Initials: _____ Date: _____

Initials: _____ Date: _____

Initials: _____ Date: _____

Initials: _____ Date: _____

Initials: _____ Date: _____

Initials: _____ Date: _____

Initials: _____ Date: _____

VOTER REGISTRATION

If you are not registered to vote where you live now, would you like to apply to register to vote here today?

If you are already registered to vote at your current address check "NO".

☐ YES ☐ NO DATE: _____

☐ YES ☐ NO DATE: _____

☐ YES ☐ NO DATE: _____

☐ YES ☐ NO DATE: _____

☐ YES ☐ NO DATE: _____

☐ YES ☐ NO DATE: _____

☐ YES ☐ NO DATE: _____

☐ YES ☐ NO DATE: _____

☐ YES ☐ NO DATE: _____

Applying to register or declining to register to vote will not affect the amount of assistance that you will be provided by WIC.

If you believe that someone has interfered with your right to register, or to decline to register to vote, you may file a complaint with the Nebraska Secretary of State, State Capital Building, Lincoln, Nebraska, 68509, (402) 471-2554.

In accordance with federal law and U. S. Department of Agricultural policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability.

To file a complaint of discrimination, write to the USDA, Director, Office of Adjudication and Compliance, 1400 Independence Ave S.W., Washington, DC, 20250-9410, or call (866) 632-9992 (voice) or (202) 260-1026 (local). USDA is an equal opportunity provider and employer.

This institution is an equal opportunity provider.

Client Name: _____ ID: _____ Family ID: _____

☐ New Cert ☐ ReCertification ☐ ReEnroll ☐ InState Transfer ☐ Out of State Transfer ☐ Presumptive ☐ Custody Change
Date Cert Expires: _____

Date of Certification: _____ Client Present: ☐ YES ☐ NO, Reason: _____

IDENTIFICATION									
Proof Seen	DL	NE WIC Fldr	SS Card	State/ Frgn ID	Work/ School ID	BC	Purple WIC Card	Hosp BC	Other (list)
Adult	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Minor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

RESIDENCY					
Proof Seen	MC	Mail	Ck Stub	Lease	Other List
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

INCOME						
Proof Seen	MC	Pay Stub	SS/ SSI	Tax Form	Child Supp	Other (list)
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Zero: Reason why _____						

30 DAY EXTENSION GIVEN	
Minor ID	Adult ID
Residency _____	
Income _____	
Date Proof Seen: _____	

NO PROOF		
<input type="checkbox"/> Res	<input type="checkbox"/> ID	<input type="checkbox"/> Income
Reason: _____		
Client Initials _____		

Staff Signature/Title	Income Assessment	ID/Residency Assessment	Nutrition Risk Assessment	Food Package Prescribing	Check Issuance
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Notification That Benefits Are About to Expire Was Given On: _____ By: _____

Ineligibility Documentation Given On: _____ Staff Initials: _____ Termination Code/Reason: _____

☐ New Cert ☐ ReCertification ☐ ReEnroll ☐ InState Transfer ☐ Out of State Transfer ☐ Presumptive ☐ Custody Change
Date Cert Expires: _____

Date of Certification: _____ Client Present: ☐ YES ☐ NO, Reason: _____

IDENTIFICATION									
Proof Seen	DL	NE WIC Fldr	SS Card	State/ Frgn ID	Work/ School ID	BC	Purple WIC Card	Hosp BC	Other (list)
Adult	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Minor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

RESIDENCY					
Proof Seen	MC	Mail	Ck Stub	Lease	Other List
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

INCOME						
Proof Seen	MC	Pay Stub	SS/ SSI	Tax Form	Child Supp	Other (list)
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Zero: Reason why _____						

30 DAY EXTENSION GIVEN	
Minor ID	Adult ID
Residency _____	
Income _____	
Date Proof Seen: _____	

NO PROOF		
<input type="checkbox"/> Res	<input type="checkbox"/> ID	<input type="checkbox"/> Income
Reason: _____		
Client Initials _____		

Staff Signature/Title	Income Assessment	ID/Residency Assessment	Nutrition Risk Assessment	Food Package Prescribing	Check Issuance
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Notification That Benefits Are About to Expire Was Given On: _____ By: _____

Ineligibility Documentation Given On: _____ Staff Initials: _____ Termination Code/Reason: _____